CORRECTED: ☐

FAMILY CLIENT TERMINATION ABSTRACTING FORM

REFER TO DATA COLLECTION PROTOCOL BEFORE COMPLETING

LEAVE NO BLANK FIELDS – REFER TO MANUAL:
UK-Unknown, NA-Does Not Apply, NC-Not Collected, CR-Client Refused

1

Clinic/Provider ID: ☐☐☐☐☐☐☐☐☐☐☐☐ Family Client Case ID: ☐☐☐☐☐☐☐☐☐☐

2

Enrollment Date: ☐☐☐☐☐☐ DOB: ☐☐☐☐☐☐ Gender: ☐

3

Last Service Date: ☐☐☐☐☐☐ Termination Type: ☐☐ Treatment Type: ☐☐ Referral Type: ☐☐ _____

4

Gambler Case ID: ☐☐☐☐☐☐☐☐☐☐ DOB: ☐☐☐☐☐☐ Gender: ☐ Relationship: ☐

5

Suicide: ☐☐ Bankruptcy: ☐☐ Abuse: ☐☐ Reported: ☐☐

6

Diagnostic Impression:
Primary: ☐☐ Secondary: ☐☐

7

Ancillary Support Services Received (Check All That Apply)

01	___ Physical Health	07	___ Employment
02	___ Mental Health	08	___ Housing
03	___ Other Addictions	09	___ Emergency Clothing
04	___ Dental	10	___ Food Stamps
05	___ Vision	11	___ Insurance Enrollment
06	___ Education	12	___ Other

8

PRINT Completed By: _____ Date: _____

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